BOARD OF INQUIRY (*Human Rights Code*)

IN THE MATTER OF the Ontario *Human Rights Code*, R.S.O. 1990, c. H.19, as amended;

AND IN THE MATTER OF the complaint by Antony Kearsley dated, January 25, 2001, alleging discrimination with respect to employment because of handicap or perceived handicap.

B E T W E E N :

Ontario Human Rights Commission

- and -

Antony Kearsley

Complainant

- and -

Corporation of the City of St. Catharines

Respondent

DECISION

Adjudicator : The Honourable Dennis F. O'Leary, Q.C.

Date : April 2, 2002

Board File No: BI-0390-01

Decision No : 02-005

Board of Inquiry (*Human Rights Code*)
505 University Avenue
5th Floor, Toronto ON M5G 2P3
Phone (416) 314-0004 Fax: (416) 314-8743 Toll free 1-800-668-3946
TTY: (416) 314-2379 / 1-800-424-1168

APPEARANCES

Ontario Human Rights Commission	)	Naomi Overend
Antony Kearsley, Complainant	)	On his own behalf
Corporation of the City of St. Catharines	)	Denis Squires

The complainant, Antony Kearsley was born May 24, 1962 and is now in his 40th year. He has atrial fibrillation described as an irregular irregular heart beat, discovered as far back as 1993. The cause of his atrial fibrillation is unknown, so his condition is described medically as lone atrial fibrillation. He has no other coronary defect. Further his atrial fibrillation, though persistent, causes him no symptoms, except that at times when he works out, he is aware that his heart beat is irregular.

He applied in 1996 to the Corporation of the city of St. Catharines for work as a fire-fighter. He passed a rigorous physical test designed to weed out those lacking the strength, endurance, conditioning and agility needed in a fire-fighter. In early June 1997 he was told by St. Catharines he was accepted as a fire-fighter with his work to commence July 7, 1997 subject to his passing a medical examination and police clearance.

St. Catharines sent Mr. Kearsley to Dr. D.I. Lorenzen (who happened to be Mr. Kearsley's family doctor) for his medical examination. While the atrial fibrillation had been noted in a hospital record when he was in a hospital in 1993 because of a car accident, Mr. Kearsley did not know he had atrial fibrillation, nor did Dr. Lorenzen, until it was discovered by virtue of an electrocardiogram test during his medical examination on June 16, 1997. When the atrial fibrillation was confirmed by a second electrocardiogram a few days later, Dr. Lorenzen told Mr. Kearsley that because of the atrial fibrillation, he was not acceptable as a fire-fighter and that he was running the risk of having a stroke. Dr. Lorenzen thought Mr. Kearsley's heart should be returned to a normal (sinus) rhythm as soon as possible. He arranged for Mr. Kearsley to see Dr. Abraham who practices in internal medicine and cardiology and later Dr. Stuart Connolly of the arrhythmia Service, Mc Master University, Faculty of Health Sciences.

Dr. Lorenzen advised St. Catharines first by telephone on July 3, 1997 and then by letter of July 9, 1997 that Mr. Kearsley because of his atrial fibrillation was not medically fit to be a fire-fighter. St. Catharines immediately advised Mr. Kearsley that he had been found unfit, but Mr. Kearsley's application was kept on file in case his condition changed for St. Catharines was

disappointed that so promising a candidate had not been found fit. St. Catharines had planned on hiring 6 fire-fighter recruits, the most promising being Mr. Kearsley, their employment and training to commence on July 7, 1997. Five recruits began their training on July 7, 1997 and the seventh most promising candidate joined them on July 15, 1997.

In May of 1998, Mr. Kearsley was hired as a fire-fighter by the City of Hamilton, his work to commence on October 5, 1998. He did begin working for Hamilton on that date and is now employed by Hamilton as a first class fire-fighter.

Mr. Kearsley's complaint against St. Catharines under the Ontario Human Rights Code R.S.O 1990 c. H.19 as amended, is that being a person believed by St. Catharines to have a handicap namely atrial fibrillation, his right to equal treatment with respect to employment, without discrimination has been infringed by St. Catharines' refusal to hire him as a fire-fighter when he was fit for the job.

The Ontario *Human Rights Code* provides in part:

> S 5 (1) Every person has a right to equal treatment with respect to employment without discrimination because of …handicap
> S 10 (1) "Because of handicap" means for the reason that person has or has had, or is believed to have or have had
> (a) any degree of physical disability…that is caused by…illness
> S 17 (1) a right of a person under this act is not infringed for the reason only that the person is incapable of performing or fulfilling essential duties or requirements attending the exercise of the right because of handicap.

It is obvious at once that a person with very bad eyesight is not discriminated against when refused a job as a truck driver nor a person with inadequate strength when refused a job as a police officer or fire-fighter. There is no doubt that St. Catharines considered that Mr. Kearsley had a physical disability, namely atrial fibrillation. The issue is whether St. Catharines was justified in concluding that because of this perceived handicap, Mr. Kearsley was incapable of performing or fulfilling essential duties of a fire-fighter.

Dr. Lorenzen's letter of July 9, 1997 to St. Catharines reads in part:

> A repeat electrocardiogram was obtained and still showed atrial fibrillation. Information on this condition has been provided under separate cover along with medical considerations in the armed forces and civil aviation.
>
> Consequently, considering the facts known to me of the wide range of tasks and the occasional strenuous exertion required of a fire-fighter in the performance of his duties, I am of the opinion that this applicant is not physically capable of performing all the duties required of an active fire-fighter, and is below, the hiring minimum medical standards for this position.
>
> The civil aviation information, provided under separate cover, contained the following:
>
> There are 3 major concerns in the assessment of the risk of incapacitation in an individual with atrial fibrillation. The first is the hemodynamic effect of the arrhythmia itself. The second is the risk of embolism and the third is the risk of bleeding as a consequence of anticoagulation. Since risk is additive the aggregate risk must remain within acceptable limits. Therefore it is possible that flying may be allowed for selected aircrew depending on their condition and the effect of treatment. The lowest risk is seen in those below 65 years of age who have intermittent or chronic lone atrial fibrillation (i.e. no identifiable cause of the arrhythmia and no underlying structural heart disease).

The armed forces information provided by Dr. Lorenzen to St. Catharines provides that a G4 medical classification for those already in the forces be assigned to

> any individual who has a medical condition that has the potential for sudden serious complications or a medical disability which is persistently mildly incapacitating. This individual usually requires barracks or home living conditions and readily available physician's services. Such personnel are considered unfit for sea or field duty, medically isolated postings and United Nations Emergency Force duty.

In his testimony at the hearing, Dr. Lorenzen said that he knew because of many years spent examining recruits for both reserve and active regiments, that Mr. Kearsley because of his atrial fibrillation would have been turned down by the Canadian Armed Forces had he tried to enlist in

June of 1997, pointing out that the guidelines provide:

> **Enrolment minimum**: this grade will be assigned to the individual whose health is commensurate with full employment without medical support in any climatic or environmental condition.

It should be noted that neither the civil aviation nor the armed forces information just referred to absolutely rule out one with lone atrial fibrillation. The armed forces information does not even mention atrial fibrillation

As stated by Dr. Lorenzen in his evidence at the hearing the material sent to St. Catharines did disclose that a pilot for the airlines in the United States was grounded if he developed atrial fibrillation. If such a pilot wishes further consideration:

> A consultation will be required 'preferably' from a specialist in internal medicine or cardiology. It must include a narrative report of evaluation, and be accompanied by an electrocardiogram with report and appropriate laboratory reports, which may include...24 hour Holter monitoring, thyroid function studies, echocardiogram and an assessment of coronary status. The report and accompanying materials should be forwarded to aeromedical certification Division AAM 300.

There was no evidence before me as to how many, if any, air crew with persistent atrial fibrillation were returned to flight duties.

It was because atrial fibrillation in his view compromises the hemodynamic function of the heart and because it creates a risk of stroke, both of which might endanger Mr. Kearsley as a fire-fighter, as well as members of the public and fellow fire-fighters, that Dr. Lorenzen rejected him as a fire-fighter for St. Catharines, both in July 1997, and as we shall see later in October 1997. Dr. Lorenzen put the risk of stroke for someone with atrial fibrillation at between 1 and 5% per year.

It was not the risk of stroke so much as the risk associated with the interference of atrial fibrillation with the hemodynamic function of the heart that was the main reason Dr. Lorenzen felt Mr. Kearsley was not medically fit to be a fireman. The risk of the heart not adequately pumping blood to the vital organs when the body is under extreme pressures due to intense heat and extreme

demands, both physical and emotional, is according to Dr. Lorenzen, quite substantial in those with atrial fibrillation. The heart and other organs including the brain of those with atrial fibrillation are more likely to fail for want of blood at maximum physical stress levels than in those without atrial fibrillation.

In the view of Dr. Lorenzen, a fire-fighter may because of the factors already mentioned suffer hemodynamic demands on the heart faced by few if any other occupations or indeed by anyone except those operating above 10,000 feet without oxygen or at times by certain scuba divers.

Dr. Lorenzen said that in certain conditions while fighting a fire, the temperature inside the fire-fighter's protective suit can approach 190° F and the fire-fighter's body temperature can rise to 40° C while his heart rate can reach 200 beats per minute. According to Dr. Lorenzen, atrial fibrillation can so interfere with blood entering the ventricle, that the ventricle can be left with inadequate blood to permit it to send a proper blood supply to the vital organs and this can result in the brain or the heart shutting down.

Dr. Lorenzen also testified that unremitting atrial fibrillation leads to enlargement of the chambers of the heart, that such process is evident in Mr. Kearsley, as both of his atria are slightly enlarged and that this tendency to cause the heart's chambers to enlarge and the walls to thicken is progressive. The point can he reached where heart failure is the result.

I return to the narrative. As mentioned earlier when Dr. Lorenzen discovered that Mr. Kearsley had atrial fibrillation he referred him to Dr. Abraham and Dr. Connolly to try to get rid of it. Mr. Kearsley passed on to those doctors that Dr. Lorenzen had told him, he would not be accepted as a fire-fighter while he had atrial fibrillation.

Dr. Abraham prescribed *Warfarin,* an anticoagulant, to dissolve any possible clots that may have formed in the atria as a result of the fluttering of the atria, before attempting pharmacological cardioversion. Dr. Abraham's effort at cardioversion with drugs failed and Mr. Kearsley went to see

Dr. Connolly. Dr. Connolly attempted electrical cardioversion without success.

Prior to attempting cardioversion, Dr. Connolly wrote on August 14, 1997 to Dr. Lorenzen in part as following:

> The patient is totally asymptomatic, is in a very good physical condition and can run a mile in 5.5 minutes...a cardioversion is pending...the nub of the issue is that this patient wants to be a fire-fighter and apparently atrial fibrillation will prevent him from doing so.... If he has a successful cardioversion and remains free of atrial fibrillation, it appears that he would be a good candidate for going back into the fire fighters. As far as his risk of stroke is concerned I think his stroke risk is very low and certainly is less than 1% per year.

After attempting electrical cardioversion without success, Dr. Connolly on September 10, 1997 sent Dr. Lorenzen a copy of the hospital discharge summary written by him, which reads in part:

> It looks like this patient is going to remain in atrial fibrillation for the foreseeable future. I do not believe that this will have any effect on his longevity, lifestyle or indeed his ability to work in the fire department. I do not believe he needs to stay on long term anticoagulation...

The discharge summary seemed to soften Dr. Lorenzen's position. He told Mr. Kearsley on September 22, 1997 that he would "butt out" and defer to Dr. Connolly's opinion, provided Dr. Connolly accepted moral and legal responsibility for the decision that Mr. Kearsley was fit to work as a fire-fighter.

Apparently at the request of Mr. Kearsley, Dr. Connolly wrote a letter to Dr. Lorenzen on October 2, 1997 which reads in part: "I do feel that the patient is not a high risk patient for working for the police force (sic) and I would support your decision to allow him to take such a job". No one suggests that by referring to "police force" rather than "fire department" Dr. Connolly caused confusion. It was obvious to all that Dr. Connolly meant the fire-department.

Dr. Lorenzen sent the letter of October 2, 1997 (but not the more positive discharge summary) to St. Cathatrines on October 15, 1997 attached to a handwritten note, which reads:

> "Jackie: attached info is further to my previous letter for your information and disposal as you see fit DL"

There was no mention of his being prepared to "butt out", if Dr. Connolly took responsibility for the decision as to fitness, and when Ms. Jackie Bowles of the St. Catharines' Human Resources Department telephoned Dr. Lorenzen about his note and the attached letter from Dr. Connolly, Dr. Lorenzen told her he did not find Mr. Kearsley fit as a fire-fighter and advised her to hire in his place someone without his risks. As a result Ms. Bowles telephoned Mr. Kearsley on October 31 and told him he was found not fit and would not be hired.

As stated earlier, it was more the concern of Mr. Kearsley's heart having lost its hemodynamic integrity, than the risk of a stroke, that lead Dr. Lorenzen to fail Mr. Kearsley as a potential fire-fighter. According to Dr. Lorenzen, it is common ground in all the literature on atrial fibrillation that eventual heart failure is a significant risk for all those with atrial fibrillation. Dr. Lorenzen said that because of the fibrillation, the atrium does not put enough blood into the ventricle to allow it to pump efficiently, and the attempt by the heart to remedy that situation leads to the enlargement and thickening already mentioned. The failure of the heart to deliver adequate blood to vital organs such as the brain and heart itself can lead to collapse especially where maximum demand is made on the heart under the extreme conditions that may be encountered in fire-fighting. The fact an echocardiogram on July 3, 1997 found both atria of Mr. Kearsley's heart to be slightly enlarged, indicates that the structural changes to his heart have already begun and Dr. Lorenzen said there is a significantly greater chance of Mr. Kearsley experiencing a lack of blood supply to a vital organ, than one with a normal sinus rhythm.

Dr. Lorenzen testified that he considered Dr. Connolly's opinion that Mr. Kearsley was fit to work as a fire-fighter to be quite unequivocal and that he felt no need to ask Dr. Connolly to

explain what his opinion was. In short, Dr. Lorenzen felt in 1997 and still feels that Mr. Kearsley carries significant risks of hemodynamic failure and stroke in spite of Dr. Connolly's opinion. Indeed, Dr. Lorenzen said that none of the reports he received from Dr. Abraham and Dr. Connolly were germane to his decision not to approve Mr. Kearsley as fit to be a fire-fighter. Since Dr. Connolly dealt in his reports with the low risk of stroke, I assume that Dr. Lorenzen means that no matter the risk of stroke he would not have approved Mr. Kearsley because of the risk of hemodynamic failure, something not mentioned by Dr. Connolly in his report.

Was Dr. Lorenzen's opinion as to risk of hemodynamic failure and stroke a medically justified opinion when rendered in 1997? I have reached the conclusion it was not justified, that is to say it was not supported by those who had studied those very problems. I, of course, must base my findings on the evidence put before me. I note in particular that no medical expert, let alone a cardiologist specializing in arrhythmia testified for St. Catharines. What I have is the evidence of Dr. Connolly, uncontradicted by any heart specialist. If fault could be found with the opinion of Dr. Connolly, surely St. Catharines would have put before me the heart specialist who would contradict it. In choosing Dr. Connolly to treat Mr. Kearsley's atrial fibrillation, Dr. Lorenzen chose well, for Dr. Connolly is the lead expert in arrhythmia in the Hamilton-St. Catharines area.

Dr. Connolly has been a cardiologist for twenty years and has spent nearly all that time in the study of, research in, and treatment of arrhythmia. He is the head of the arrhythmia service run by McMaster University, indeed was the founder of it. He has been a full professor at McMaster since 1994. Atrial fibrillation is the most common arrhythmia that he encounters. He has had papers published on various aspects of atrial fibrillation as follows: 3 in 1991, 2 in 1994, 5 in 1996, 4 in 1997, 1 in 1998, 2 in 1999, 4 in 2000, 4 in 2001. He is responsible for numerous medical journal abstracts on atrial fibrillation, as noted in Tab 32 of Exhibit 2. Uncontradicted as it is by anyone with like or even general expertise, I accept Dr. Connolly's evidence in total.

As to hemodynamic failure, Dr. Connolly testified that it is an old fashioned but incorrect view that atrial fibrillation in someone like Mr. Kearsley without symptoms, would result in

interference with the heart supplying blood to the vital organs of the body. Surveys, he said, have shown otherwise. While the atrium does contribute to overall heart function by helping fill the lower chamber and is responsible for 10% of the function of filling the lower heart chamber with blood, evidence indicates that in lone, asymptomatic atrial fibrillation, the heart compensates by increasing its output without that 10% contribution from the atrium. Dr. Connolly said that even in the most stressful situations, with the greatest demands on his heart, Mr. Kearsley should function extremely well. More important for optimum function in such situations, than his atrial fibrillation, is his good physical condition and proper sleep the night before any such extreme demand.

As to his heart deteriorating over time because of the atrial fibrillation, his prognosis is good in the long term, As stated in Dr. Connolly's discharge summary of September 10, 1997, the atrial fibrillation will have no effect "on his longevity, lifestyle or indeed his ability to work in the fire department". Dr. Connolly said the slight enlargement of both atria in Mr. Kearsley's echocardiogram of July 23, 1997 is not the commencement of heart deterioration but what one would expect to see in someone with asymptomatic atrial fibrillation.

As regards hemodynamic and stroke risks in Mr. Kearsley, Dr. Connolly in his letter of February 6, 2002, filed at the hearing, had this to say:

> Patients who are under 65 years of age and whose hearts are otherwise normal, face an extremely low risk of stroke, in the range of 0.2 %...Based on careful epidemiological studies done in the 1980's and early 1990's it was well established that atrial fibrillation in a patient whose heart was otherwise normal would not impede the ability to perform even the extreme functions of a fire-fighter. The effect of atrial fibrillation on cardiac function is well known, and in a patient whose heart is otherwise normal the effects are minor. The risk of stroke in such patients is also so small as to not represent any significant risk to the patient, his fellow workers or the public. Therefore, in my opinion, the fact that Mr. Kearsley had atrial fibrillation should not have prevented his employment as a fire-fighter.

I have no doubt if Dr. Lorenzen had telephoned Dr. Connolly in September or October 1997 as to why their opinions as to risk differed, that Dr. Connolly would have told Dr. Lorenzen in substance, what I have just quoted from his letter of February 2002.

It is the medical information that existed in 1997, not now, that is relevant on the question of the justification of Dr. Lorenzen's decision to disqualify Mr. Kearsley. Dr. Connolly's opinion in 1997 that Mr. Kearsley's risk of stroke was very low stands confirmed by studies done at the Mayo Clinic. In a study on those diagnosed prior to age 60 years with lone atrial fibrillation, and no other cardiovascular risk factors, completed in 1985, and published September 10, 1987 in The New England Journal of Medicine, it was found that:

> There was no significant difference in survival among the subgroups with isolated, recurrent, and chronic atrial fibrillation or between the groups as a whole and an unselected regional population with the same age and sex distribution as the study groups...During the more than 1400 person-years of follow up, five patients had a stroke, that is 0.35 stroke per 100 person-years...When half the patients were still under observation in the 15th year, only one stroke had occurred . At the end of the 15th year, 1.3 percent of the patients had had a stroke...Judging from the Rochester Minnesota, population in 1950 through 1979 with the same age and sex distribution as the study group, 3 percent would have expected to have a stroke in 15 years. This population sample, however, includes the usual distribution of patients with cardiovascular risk factors...Our finding of only 5 strokes, of which four were attributed to thromboemboli from lone atrial fibrillation during more than 1400 person-years of follow-up is quite low.

The age at which events due to emboli from atrial fibrillation occurred were as follows:

- stroke: 74, 66, 71, 81
- myocardial infarction: 82, 66, 76, 80

So not only was the risk of stroke 0.35% per year very low, but all strokes and heart attacks that may have been caused by emboli resulting from atrial fibrillation occurred in patients more than 65 years of age. Fire-fighters are forced to retire on reaching 60 years of age.

The Mayo Clinic study indicates that the risk of having a stroke some day because of lone atrial fibrillation is very low 0.35% per year, but is perhaps so low as not to be measurable for having a stroke before age 60. No one at the hearing took issue with Dr. Lorenzen's opinion that the risk of stroke in healthy fit young men of like age of Mr. Kearsley is practically 0. But the evidence satisfies

me that he is wrong that Mr. Kearsley had a 1% to 5 % chance of a stroke every year. Dr. Connolly put that risk at 0.2% per year and the Mayo Clinic survey would suggest that prior to age 60, even that percentage may be too high.

In his evidence, Dr. Connolly said he was surprised that Dr. Lorenzen had not gotten more information from him before turning Mr. Kearsley down as a fire-fighter: "I am surprised he did not call me, being the local expert in arrhythmia, to find out why I thought him fit" he said.

I also feel Dr. Lorenzen should have called Dr. Connolly to find out why their opinions differed. He knew Dr. Connolly an expert in arrhythmia was stating quite clearly that Mr. Kearsley was physically fit as a fire-fighter and the atrial fibrillation would have no effect on his longevity, life style or ability to work in the fire department. Dr. Muir, a general practitioner who examined Mr. Kearsley on behalf of the City of Hamilton on being shown Dr. Connolly's letter stating that Mr. Kearsley was not a high risk patient and should be allowed to work as a fire-fighter, immediately found him fit. It is not acceptable that a general practitioner, even one with the experience of Dr. Lorenzen as to the minimum physical requirements for army recruits, and those seeking to obtain or retain a licence to fly should rely on his own stereotypes or on the criteria set by the armed forces or civil aviation authorities in the face of opinion evidence from one such as Dr. Connolly that Mr. Kearsley was fit to work as a fire-fighter. Rather Dr. Lorenzen should have explored the matter further with Dr. Connolly and if still not satisfied should have consulted another such expert. By relying on out-dated medically unfounded absolute rules he found unfit, one who was completely fit as a fire-fighter.

St. Catharines makes the argument that if lone atrial fibrillation did not make Mr. Kearsley unfit, why did Doctors Abraham and Connolly both try to convert his heart to sinus rhythm? The answer is simple. Dr. Lorenzen had told Mr. Kearsley he could not work as a fire-fighter while he had atrial fibrillation. The surest way to get around the problem was to accomplish cardioversion.

Dr. Lorenzen stated any increase in risk beyond that carried by a health young man not

suffering from atrial fibrillation should not be tolerated in hiring a fire-fighter. That view is obviously too stringent, but certainly any significant increase in risk should disqualify a candidate. Dr. Lorenzen could have been justified in thinking had he telephoned and obtained Dr. Connolly's explanation that Mr. Kearsley had an increased risk of stroke of 0.2% per year. Is such a risk significant? It seemed at the hearing to be accepted by all parties that a fire-fighter works at his job, ¼ of the total hours in a year. Fire Chief Jones accepted that during 20% of a fire-fighters' working hours, a fire-fighter might be engaged in such work that he might endanger himself, the public or other fire-fighters if he had a stroke. The increased odds of Mr. Kearsley having a stroke at such times is then: 1/4 X 1/5 X 2% = 0.01% per year.

St. Catharines called no evidence nor made any suggestion as to what would constitute an unacceptable increase in risk beyond the statement of Dr. Lorenzen that no increase in risk can be tolerated.

In my view, 0.01% per year is such a miniscule increase in risk as to be insignificant and irrelevant in deciding whether a man is fit for fire-fighting. I am satisfied that Mr. Kearsley was completely fit to be a fire-fighter.

Defences raised by St. Catharines and my disposition of them.

I) Lone atrial fibrillation is not a handicap because it does not fit within the description of handicap found in Sec 10 (1) (a) of the *Code* namely, "any degree of physical disability.... caused by bodily injury, birth defect or illness" because the cause of lone atrial fibrillation is unknown.

Answer: While its cause is unknown, sole atrial fibrillation is an interruption with the normal beating of the heart and so is an illness, causing the perceived or believed inability of Mr. Kearsley to be a fire-fighter. Lone atrial fibrillation does then fit within the description.

II) Some of the medical information came to Dr. Lorenzen in his capacity as Mr. Kearsley's family doctor and St. Catharines is only responsible for decisions made by Dr. Lorenzen on medical information he received as St. Catharines medical examiner.

Answer: In my view, Dr. Lorenzen had to decide on the basis of all the medical information available to him, whether Mr. Kearsley was fit to work as a fire-fighter. He owed an obligation to both St. Catharines and Mr. Kearsley to do that. It is not relevant that he was also Mr. Kearsley's family doctor.

III) In conducting the medical examination of Mr. Kearsley, Dr. Lorenzen was only required to possess and use the skill of a general practitioner, not that of an expert in cardiology.

Answer: Even if that be the test, Dr. Lorenzen failed to do what a reasonably competent general practitioner would have done, namely pay heed to the opinion of an expert, or consult another expert if not satisfied with that of the first expert. Dr. Foreman and Dr. Muir both general practitioners said that on discovering atrial fibrillation, they would neither fail nor pass the candidate, but seek further information. Neither would have done as Dr. Lorenzen did, fail Mr. Kearsley in July 1997 without waiting for the experts' advise. Dr. Muir certainly would not have failed Mr. Kearsley in October 1997, ignoring Dr. Connolly's opinion. Dr. Muir immediately accepted it and found Mr. Kearsley fit as a fire-fighter.

IV) Medical opinion was uncertain and divided in 1997 as to the risks raised by atrial fibrillation.

Answer: The evidence discloses no such uncertainty or division amongst those qualified to judge those risks. Dr. Lorenzen had before him the opinion of the local expert in arrhythmia, which he ignored in deciding that Mr. Kearsley was not fit.

CONCLUSION:

I find that Dr. Lorenzen was not justified in finding that Mr. Kearsley because of atrial fibrillation was incapable of performing or fulfilling all the essential duties of a fire-fighter. Since Dr. Lorenzen is the expert to whom St. Catharines delegated the task of determining whether he was medically fit then under Section 45 (1) of the *Code*, Dr. Lorenzen's act of failing him becomes the act of St. Catharines. Indeed Dr. Lorenzen was removed as a personal respondent in these proceedings by order of Matthew D. Garfield, Chair of the Board of Inquiry on Dec 12, 2001 on St. Catharines admitting that "Dr. Lorenzen was an agent …of St. Catharines …to give an opinion of [Antony Kearsley's] medical fitness to perform the duties of an active full-time fire-fighter…"

I therefore find that the complaint against St. Catharines has been proven. St. Catharines has infringed the right of Antony Kearsley a person with a perceived handicap to be free from discrimination in regard to employment as a fire-fighter, contrary to Section 9 of the *Human Rights Code.*

Remedy:

I) St. Catharines through its Fire Chief stated at the hearing that it could commence training Mr. Kearsley, to the extent he needs training, virtually immediately, as there are enough vacancies to permit 2 new recruits to be trained. I note that the City has never undertaken to train less than 2 recruits at one time, in order to avoid costly disruption and waste of time. I therefore direct the City of St. Catharines to hire Mr. Kearsley as a first class fire-fighter, his work to commence at such time within the next 75 days as meets the convenience of St. Catharines and Mr. Kearsley.

II) I find that St. Catharines should have hired Mr. Kearsley as of June 8, 1998. Once it was confirmed on June 20 1997 that Mr. Kearsley had atrial fibrillation, it was necessary to determine whether he had any other cardiovascular problems before he could be found fit for fire-fighting. It is most unlikely that the necessary tests, examinations and opinions could have been accomplished in time for him to commence work on July 7, 1997 or indeed by July 15, 1997. While Dr. Abraham wrote a note on June 30, 1997 stating Mr. Kearsley could work as a fire-fighter, that note was written before any tests had been performed. In his report of June 27, 1997 to Dr. Lorenzen, Dr. Abraham suggested the atrial fibrillation might be due to alcohol or caffeine and those should be avoided. The report of an echocardiogram performed on July 3, 1997 did not reached Dr. Lorenzen until July 7, 1997.

We do not know just when Dr. Abraham might have delivered a full report attesting to Mr. Kearsley's fitness as a fire-fighter, but even if such could have been prepared and delivered to Dr. Lorenzen by July 7 or shortly thereafter, Dr. Lorenzen could very reasonably have wanted the opinion of a cardiologist or expert in arrhythmia such as Dr. Connolly. It is speculation I am not prepared to engage in to find that Dr. Lorenzen could have been satisfied that Mr. Kearsley was fit as a fire-fighter in time for him to commence training with the other recruits in July 1997.

Having failed, without the fault of Dr. Lorenzen or St. Catharines, to pass his medical examination in time to start working in July 1997, he was no more entitled than anyone else to require St. Catharines to hire him until St. Catharines next hired and trained recruits. Dr. Lorenzen was wrong in finding Mr. Kearsley unfit in October, but that meant only St Catharines was wrong in not taking him on as a fire-fighter when the next hiring took place which turned out to be June 8, 1998.

I award Mr. Kearsley any net loss in wages resulting from the fact he was not hired by St. Catharines as of June 8, 1998. He is not to be penalized if he earned less working at an hotel than at some higher paying job he might have found. He knew by June 8, 1998 that he was going to be working for Hamilton as of October 5, 1998 and in the months prior to June 1998, he was hoping for a quick decision in regard to his claim of discrimination that would require St. Catharines to hire him. It was reasonable that he did not look for other work.

III) When Mr. Kearsley commences work for St. Catharines he is to be given seniority ahead of all those hired on June 8, 1998 because it was St. Catharines' obligation to hire him before anyone else, when following its erroneous decision, it next hired a fire-fighter.

IV) Mr. Kearsley is also to be compensated by St. Catharines for any pension loss, overtime loss and mileage loss because he was not hired by St. Catharines as of June 8, 1998. The wage, pension, overtime and mileage losses I leave to the parties to work out. I remain seized of this matter until all matters flowing from my decision are worked out or determined by me. I invite the parties to let me know if there be any obvious errors, omissions or misstatement in my reasons. The hearing was not recorded and I acknowledge the difficulty that creates.

V) General Damages: Section 41 of the *Code* reads in part:

> (1) Where the board of inquiry, after a hearing, finds that a right of the complainant under Part I has been infringed and that the infringement is a contravention of section 9 by a party to the proceeding, the board may, by order,
>
> (a) direct the party to do anything that, in the opinion of the board, the party ought to do to achieve compliance with this Act, both in respect of the complainant and in respect of future practices; and
>
> (b) direct the party to make restitution, including monetary compensation, for loss arising out of the infringement, and, where the infringement

> has been engaged in wilfully and recklessly, monetary compensation may include an award, not exceeding $10,000, for mental anguish. R.S.O. 1990. c. H. 19, s. 41 (1).

Neither Dr. Lorenzen nor St. Catharines were wilful or reckless in denying employment to Mr. Kearsley. Dr. Lorenzen acted in the mistaken but firmly held belief that Mr. Kearsley had a serious condition that needed urgent treatment and made him ineligible to be a fire-fighter. St. Catharines was disappointed he was not cleared in July to be a fire-fighter, and kept his file open until Dr. Lorenzen removed all hope in October 1997. There can be no award therefore for *mental anguish.* I am further of the view that in any event Mr. Kearsley suffered no mental anguish as a result of Dr. Lorenzen finding him unfit to be a fire-fighter. Mental anguish means more than disappointment. The Random House dictionary describes anguish as follows: "excruciating or acute distress, suffering or pain, syn of agony, torment, torture". Such distress must of course be mental as opposed to physical.

The words in Section 41 (1) (b) "direct the party to make restitution, including monetary compensation, for loss arising out of the infringement" suggest to me that the Board of Inquiry is only empowered by those words to order restitution in the amount of the monetary loss suffered because of the infringement, that is to say the special damages suffered because of the infringement. Were it not for the decision of the Divisional Court in *The Shelter Corporation et al. v Ontario Human Rights Commission*, (2001) 39 C.H.R.R. D/111, I would not have thought that those words permit as well an award of general damages, being inclined to the view that when the legislature intended to provide for an award for mental suffering, it spelled it out, but limited the award to "$10,000" for "mental anguish" where the respondent has been wilful or reckless, making it unlikely the legislature intended to provide for an award of unlimited general damages for lesser mental suffering when the respondent has been only negligent.

Accepting that an award of general damages can be made without the respondent being wilful or reckless I must then decide on the appropriate award in this case.

Here Mr. Kearsley quickly knew he was fit to be a fire-fighter and that Dr. Lorenzen was wrong. Mr. Kearsley recognized that a mistake had been made and by laying a complaint he set about having it corrected. He knew Dr. Lorenzen was not trying to diminish him and he was not diminished. Mr. Kearsley has been awarded overtime, that he did not work, and that should go a long way toward compensating him for time spent on the road while working in Hamilton. In all the circumstances I feel the appropriate award for general damages is $4,000 and I so fix the amount.

ORDER

1) St. Catharines to hire Mr. Kearsley as a first class fire-fighter, his work to commence within 75 days.

2) St. Catharines to pay Mr. Kearsley for his monetary loss resulting from its failure to hire him on June 8, 1998, such loss being his loss of wages, overtime, pension and mileage.

3) St. Catharines to give Mr. Kearsley seniority ahead of those hired on June 8, 1998.

4) St. Catharines to pay Mr. Kearsley general damages of $4,000 for discriminating against him.

Date at Toronto this ____day of April, 2002.

The Honourable Dennis F. O'Leary, Q.C.
Member